SECTION 17 - CLAIMS DISPOSITION

SECTION 17-CLAIMS DISPOSITION

This section of the manual provides information used to inform the provider of the status of each processed claim.

MO HealthNet claims submitted to the fiscal agent are processed through an automated claims payment system. The automated system checks many details on each claim, and each checkpoint is called an edit. If a claim *cannot* pass through an edit, it is said to have failed the edit. A claim may fail a number of edits and it then drops out of the automated system; the fiscal agent tries to resolve as many edit failures as possible. During this process, the claim is said to be suspended or still in process.

Once the fiscal agent has completed resolution of the exceptions, a claim is adjudicated to pay or deny. A statement of paid or denied claims, called a Remittance Advice (RA), is produced for the provider twice monthly. Providers receive the RA either on paper or via the Internet. The Internet RAs appear in a similar format as those received on paper.

New and active providers wishing to download and receive their RAs via the Internet are required to sign up for Internet access. At www.dss.mo.gov/mhd providers may apply for Internet access from either the “Apply for Internet Access” link in the Quick Links section or providers may select the “internet access” link under the Provider Information section. Either link takes the user to the on-line Application for MO HealthNet Internet Access Account. Providers are unable to access the web site without proper authorization. An authorization is required for each individual user.

17.1 ACCESS TO REMITTANCE ADVICES

Providers receive either a mailed paper RA or receive an electronic (RA) (via the eMOMED Internet website at www.emomed.com or through an ASC X12N 835). Providers do *not* receive both paper and electronic RAs. Providers still receiving a mailed paper copy are encouraged to sign up for Internet access to the RAs.

Accessing the RA via the Internet gives providers the ability to:

- Retrieve the RA the Monday following the weekend Financial Cycle (two weeks sooner than if receiving paper copies);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from an office desktop; and
- Download the RA into the office operating system.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the office PC and print at any convenient time.

Access to this information is restricted to users with the proper authorization. The Internet site is available 24 hours a day, 7 days a week with the exception of scheduled maintenance.

17.2 INTERNET AUTHORIZATION

If a provider uses a billing service to submit and reconcile MO HealthNet claims, proper authorization *must* be given to the billing service to allow access to the appropriate provider files.

If a provider has several billing staff who submit and reconcile MO HealthNet claims, each Internet access user *must* obtain a user ID and password. Internet access user IDs and passwords *cannot* be shared by co-workers within an office.

17.3 ON-LINE HELP

All Internet screens at www.emomed.com offer on-line help (both field and form level) relative to the current screen being viewed. The option to contact the Infocrossing Healthcare Services Help Desk via e-mail is offered as well. As a reminder, the help desk is only responsible for the Application for MO HealthNet Internet Access Account and technical issues. The user should contact the Provider Relations Communication Unit at (573) 751-2896 for assistance on MO HealthNet Program related issues.

17.4 REMITTANCE ADVICE

The Remittance Advice (RA) shows payment or denial of MO HealthNet claims. If the claim has been denied or some other action has been taken affecting payment, the RA lists message codes explaining the denial or other action. A new or corrected claim form *must* be submitted as corrections *cannot* be made by submitting changes on the RA pages.

Claims processed for a provider are grouped by paid and denied claims and are in the following order within those groups:

Crossovers
Inpatient
Outpatient (Includes Rural Health Clinic and Hospice)
Medical
Nursing Home
Home Health
Dental
Drug

Capitation
Credits

Claims in each category are listed alphabetically by participant's last name. Each category starts on a separate RA page. If providers do *not* have claims in a category, they do *not* receive that page.

If a provider has both paid and denied claims, they are grouped separately and start on a separate page. The following lists the fields found on the RA. Not all fields may pertain to a specific provider type.

FIELD NAME	FIELD DESCRIPTION
PAGE	The remittance advice page number.
CLAIM TYPE	The type of claim(s) processed.
RUN DATE	The financial cycle date.
PROVIDER IDENTIFIER	The provider's 9-digit MO HealthNet number.
RA #	The remittance advice number.
PROVIDER NAME	The name of the provider.
PROVIDER ADDR	The provider's address.
PARTICIPANT NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are *not* on file, only the first two letters of the last name and the first letter of the first name appear.
MO HEALTHNET ID	The participant's current 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11 — Paper Drug 15 — Paper Medical 18 — Paper Medicare/MO HealthNet Part B Crossover Claim 40 — Magnetic Tape Billing (MTB)—includes crossover claims sent by Medicare intermediaries. 41 — Direct Electronic MO HealthNet Information (DEMI) 43 — MTB/DEMI 44 — Direct Electronic File Transfer (DEFT) 45 — Accelerated Submission and Processing (ASAP) 46 — Adjudicated Point of Service (POS) 47 — Captured Point of Service (POS) 49 — Internet 50 — Individual Adjustment Request

	55 — Mass Adjustment 70 — Individual Credit to an Adjustment 75 — Credit Mass Adjustment
	The third and fourth digits indicate the year the claim was received.
	The fifth, sixth and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year).
	The last digits of an ICN are for internal processing.
	For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number. On drug claims this field is populated with the prescription number.
CLAIM: ST	This field reflects the status of the claim. Valid values are: 1 — Processed as Primary 3 — Processed as Tertiary 4 — Denied 22 — Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), participant copay and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line in MMDDYY.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code is *not* present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. NOTE: The revenue code only appears in this field if a procedure code has also been submitted.

QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure/service.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The MO HealthNet ID number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code, which is a code identifying the general category of payment adjustment. Valid values are: CO — Contractual Obligation CR — Correction and Reversals OA — Other Adjustment PI — Payer Initiated Reductions PR — Patient Responsibility
RSN	The Claim Adjustment Reason Code, which is the code identifying the detailed reason the adjustment was made. Valid values can be found at http://www.wpc-edi.com/codes/claimadjustment.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field is *not* printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Valid values are: HE — Claim Payment Remark Codes RX — National Council for Prescription Drug Programs Reject/Payment Codes The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code. Valid values can be found at http://www.wpc-edi.com/codes/remittanceadvice.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount,

	allowed amount, and paid amount.
CHECK AMOUNT	The total check amount for the provider.
EARNINGS REPORT	
PROVIDER IDENTIFIER	The provider's 9-digit MO HealthNet number.
RA #	The remittance advice number.
EARNINGS DATA	
NO. OF CLAIMS PROCESSED	The total number of claims processed for the provider.
DOLLAR AMOUNT PROCESSED	The total dollar amount processed for the provider.
CHECK AMOUNT	The total check amount for the provider.

17.5 CLAIM STATUS MESSAGE CODES

Missouri no longer reports MO HealthNet-specific Explanation of Benefits (EOB) and Exception message codes on any type of remittance advice. As required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Version 5.0 Reject Codes for Telecommunication Standard are used.

Listings of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes can be found at http://www.wpc-edi.com/content/view/180/223/. A listing of the NCPDP Version 5.0 Reject Codes for Telecommunication Standard can be found in the NCPDP Version 5.Ø Reject Codes For Telecommunication Standard appendix.

17.5.A FREQUENTLY REPORTED REDUCTIONS OR CUTBACKS

To aid providers in identifying the most common payment reductions or cutbacks by MO HealthNet, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

Claim Payment Reduction/Cutback	Claim Group Code	Description	Claim Adjustment Reason Code	Description
Payment reimbursed at the maximum allowed	CO	Contractual Obligation	45	Charges exceed our fee schedule, maximum allowable

				or contracted or legislated fee arrangement.
Payment reduced by other insurance amount	OA	Other Adjustment	23	Payment adjusted because charges have been paid by another payer
Medicare Part A Repricing	OA	Other Adjustment	45	Charges exceed our fee schedule, maximum allowable or contracted or legislated fee arrangement.
Payment cut back to federal percentage (IEP therapy services)	OA	Other Adjustment	A2	Contractual adjustment
Payment reduced by co-payment amount	PR	Patient Responsibility	3	Co-Payment amount
Payment reduced by patient spenddown amount	PR	Patient Responsibility	178	Payment adjusted because patient has *not* met the required spenddown
Payment reduced by patient liability amount	PR	Patient Responsibility	142	Claim adjusted by monthly MO HealthNet patient liability amount

17.6 SPLIT CLAIM

An ASC X12N 837 electronic claim submitted to MO HealthNet may, due to the adjudication system requirements, have service lines separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split is assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within MO HealthNet's MMIS, a maximum of 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed in the internal MMIS detail record are split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on the internal MMIS claim record is used to create an additional claim.

17.7 ADJUSTED CLAIMS

An adjusted claim starts with an ICN of 50, 55, 70 or 75. Adjustments are processed when the original claim was paid incorrectly.

If the ICN starts with a 50, there is a matching ICN starting with 70 (an ICN starting with a 55 has a matching ICN starting with 75). A credit (negative payment) is made for the incorrect amount (ICN 70 or 75). Then a payment is made for the correct amount (ICN 50 or 55). If the adjustment is submitted via the Internet website www.emomed.com, only a 70 and a 49 ICN appear on the RA.

If a payment should *not* have been made at all, then there is *not* a 50 or 55 ICN, but only the 70 or 75 ICN (the credit for the incorrect payment).

17.8 SUSPENDED CLAIMS (CLAIMS STILL BEING PROCESSED)

Suspended claims are *not* listed on the Remittance Advice (RA). To inquire on the status of a submitted claim *not* appearing on the RA, providers may either submit a 276 Health Care Claim Status Request or may submit a View Claim Status query using the Real Time Queries function online at www.emomed.com. The suspended claims are shown as either paid or denied on future RAs without any further action by the provider.

17.9 CLAIM ATTACHMENT STATUS

Claim attachment status is not listed on the Remittance Advice (RA). Providers may check the status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Participant (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- Sterilization Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Participant ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

17.10 PRIOR AUTHORIZATION STATUS

Providers may check the status of Prior Authorization (PA) Requests using the Real Time Queries function on-line at www.emomed.com. PA status queries are restricted to the provider who submitted the Prior Authorization Request.

17.11 POS RESPONSES

The provider receives one of five different responses from the point of service (POS) following the submission of a claim.

17.11.A RESPONSE FOR PAID CLAIM

A paid claim is a claim with no exceptions which cause denial or prevent further processing.

NCPD FIELD NAME AND NUMBER	FIELD VALUES
102 Version Number	Versions 3.2, 3.C and more current versions are supported.
103 Transaction Code	01—One claim paid 02—Two claims paid 03—Three claims paid 04—Four claims paid
501 Response Status	A value of ‘P’ is returned for a paid claim.
505 Deductible	This field is *not* used and is always equal to zero
506 Ingredient Cost Paid	This field is *not* used and is always equal to zero
508 Sales Tax	This field is *not* used and is always equal to zero
509 Total Amount Paid	This field is the MO HealthNet Reimbursement Amount (includes

		dispensing fee).
503	Auth #	This field contains the 13-digit MO HealthNet Internal Control Number (ICN), which appears on the Remittance Advice.
504	Message	This 40-character field may contain one or more messages.

17.11.B RESPONSE FOR A REJECTED CLAIM

A rejected claim is one with one or more exceptions which cause denial

NCPD FIELD NAME AND NUMBER		FIELD VALUES
102	Version Number	Versions 3.2, 3.C and more current versions are supported.
103	Transaction Code	01—One claim rejected 02—Two claims rejected 03—Three claims rejected 04—Four claims rejected
501	Response Status	A value of “R” is returned for a rejected claim.
510	Reject Count	The number of NCPDP reject codes.
511	Reject Count ##	The NCPDP reject code. Up to 20 codes may be present. Each reject code represents a denial reason.
504	Message	The first 13 positions of this field contain the MO HealthNet Internal Control Number (ICN) which appears on the Remittance Advice. If reject code “85” appears if field #$511, the remaining 29 positions of this field contain a MO HealthNet specific (non-NCPDP) denial message.

17.11.C RESPONSE FOR A CAPTURED CLAIM

A captured claim is one with one or more exceptions which prevent the claim from processing through the POS system. The claim is processed during the fiscal agent's next batch (internal) cycle. The final disposition of the claim is reported on the Remittance Advice.

NCPD FIELD NAME AND NUMBER	FIELD VALUES
102 Version Number	Versions 3.2, 3.C and more current versions are supported.
103 Transaction Code	01—One claim captured 02—Two claims captured 03—Three claims captured 04—Four claims captured
501 Response Status	A value of "C" is returned for a captured claim.
503 Auth #	The 13-digit MO HealthNet Internal Control Number (ICN), which appears on the Remittance Advice.
504 Message	This 70 character field contains a message explaining why the claim could *not* be processed through the POS system.

17.11.D RESPONSE FOR AN ACCEPTED REVERSAL

An accepted reversal is one which found a paid claim meeting the reversal criteria entered and credited that claim.

NCPD FIELD NAME AND NUMBER	FIELD VALUES
102 Version Number	Versions 3.2, 3.C and more current versions are supported.
103 Transaction Code	11—Claim *not* reversed
501 Response Status	A value of "A" is returned for an accepted

	reversal.
503 Auth #	The 13-digit MO HealthNet Internal Control Number (ICN), which appears on the Remittance Advice.
504 Message	This 70 character field contains a message stating that a claim has been reversed.

17.11.E RESPONSE FOR A REJECTED REVERSAL

A rejected reversal is one which did *not* find a paid claim meeting the reversal criteria entered.

NCPD FIELD NAME AND NUMBER	FIELD VALUES
102 Version Number	Versions 3.2, 3.C and more current versions are supported.
103 Transaction Code	11—Claim *not* reversed.
501 Response Status	A value of "R" is returned for a rejected reversal.
510 Reject Count	The number of NCPDP reject codes.
511 Reject Count ##	The NCPDP reject code. Up to 10 codes may be present. Each reject code represents a reason a claim was *not* reversed.
504 Message	This 62 character field may contain one or more messages.

17.11.F PROSPECTIVE DRUG USE REVIEW

17.11.F(1) Overview

As a result of OBRA '90, the MO HealthNet Division is implementing a prospective Drug Use Review (DUR) process to provide screening for potential drug therapy problems. The MO HealthNet Pharmacy Point of Service (POS) System performs prospective DUR screening on each prescription submitted for:

* The current date of service

* Non-nursing home participants.

The prospective DUR process has been jointly developed by the MO HealthNet Division and Infocrossing Healthcare Services, using clinical modules provided by First DataBank. These modules, and the Duration of Therapy module developed by the MO HealthNet Division, have been reviewed and approved for this use by the MO HealthNet DUR Board.

The following screens are performed by the pharmacy point of service system:

* Early Refill
* Dose Range Checking
    * High Dose Alert
    * Low Dose Alert
* Minimum/Maximum Daily Dose
    * High Dose Alert
    * Low Dose Alert
* Drug to Drug Interactions
* Drug Disease Contraindications
    * Drug (Actual) Disease Precaution
    * Inferred Drug Disease Precaution
* Duplicate Therapy Checking
    * Therapeutic Duplication
    * Ingredient Duplication
* Side Effects
    * Additive Toxicity Side Effect
    * Medical Condition/Additive Side Effect
    * Side Effect
    * Drug Indicated for Side Effect of previously prescribed drug
* Duration of Therapy (H2)
    * Excessive Duration Alert

Clinical modules are provided by First DataBank, with the exception of Duration of Therapy (H2) which was developed by the Department of Social Services-MO HealthNet Division.

Warning messages have been developed for each DUR function. The MO HealthNet pharmacy point of service system accepts the following telecommunication standards:

* NCPDP Version 3.2

* NCPDP Version 3.C

17.11.F(2) NCPDP Version 3.2/3.C

DUR messages were developed in accordance to the NCPDP standards. Up to three DUR Messages (NCPDP field #525) are provided. Effective January 1, 1993 MO HealthNet required NCPDP version 3.2 or 3.C for all pharmacy point of service transactions. If there are questions please ask the *software vendor* to contact Infocrossing Healthcare Services at (573) 635-2434.

Drug Conflict Code XX

DD = Drug-Drug Interactions

ER = Early Refill

LD = Low Dose Alert

HD = High Dose Alert

MX = Excessive Duration Alert

PR = Prior Adverse Drug Reaction

DC = Inferred Drug Disease Precaution

MC = Drug (Actual) Disease Precaution

TD = Therapeutic Duplication

ID = Ingredient Duplication

SE = Side Effect

Severity Code Index 1

1 = Major

2 = Moderate

3 = Minor

Only drug conflicts with a severity index of "1" (Major) are identified.

Other Pharmacy Indicator X

0 = No Value

1 = Your Pharmacy

3 = Other Pharmacy

Previous Date of Fill XXXXXXXX

Zeros if conflict is based on medical condition.

Quantity of Previous Fill XXXX

Zeros if conflict is based on medical condition.

DataBase Indicator X

1 = First DataBank

5 = Other Source

Other Prescriber Indicator X

0 = No Value

1 = Same Prescriber

2 = Other Prescriber

Free Text XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

DUR Overflow X

0 = Not Specified

1 = No Overflow

2 = Overflow

17.11.F(3) Glossary of Terms

Active prescription—A prescription for which 70% of the days supply has *not* yet been used.

The Drug to Drug Interactions module considers a drug active from the date of service plus the days supply plus eight days.

Chronic condition—Certain conditions coded into the system which are maintained in the participant's medical history for the lifetime of that participant. Other diagnoses are maintained for 120 days.

Current prescription—The prescription for which the point of service response has been transmitted.

DUR overflow indicator—A field which indicates whether or not additional DUR messages were generated for the current prescription, but which were *not* transmitted due to space considerations.

Inferred disease—A condition identified by the use of a medication commonly used to treat that disorder. For example, Phenytoin would be used to infer a seizure disorder when the diagnosis of "seizure disorder" does *not* appear in the participant's medical history profile.

Medical history profile—Diagnoses taken from paid MO HealthNet claims (e.g. Physician, Inpatient and Outpatient Hospital, Dental, Nursing Home, and Home Health). Certain chronic conditions are maintained in the participant's medical history profile for a lifetime while the remainder are maintained for 120 days.

Prescription history profile—A profile of a participant's active prescriptions.

17.11.F(4) Dose Range Checking

Purpose: Checks prescription dosage level for an acceptable range. A value for units per day is calculated by dividing quantity dispensed by days supply. This value is compared to minimum and maximum unit values for the participant's age group. Other disease states are *not* linked to the dose range information (such as renal failure). Dose Range calculations are limited by the lack of data regarding patient weight.

17.11.F(5) Minimum/Maximum Daily Dose

Purpose: Provides a "quick check" verification that the prescription lies within minimum and maximum recommended adult daily dosages for most frequently prescribed drugs without regard to indication. This module is only executed when no Dose Range information is available.

LD—Low Dose Alert

The "Low Dose Alert" warning message is issued when a prescription's daily dosage is below the advised dosage.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	LD	(Low Dose Alert)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	0	(No Value)
Previous Date of Fill	00000000	
Quantity of Previous Fill	00000	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	0	(No Value)
Free Text	MIN DOSE = 3.0 UNITS/DAY	

HD—High Dose Alert

The "High Dose Alert" warning message is issued when a prescription's daily dosage is above the advised dosage.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	HD	(High Dose Alert)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	0	(No Value)
Previous Date of Fill	00000000	
Quantity of Previous Fill	00000	
DataBase Indicator	1	(First DataBank)

Other Prescriber Indicator	0	(No Value)
Free Text	MAX DOSE = 1.0 UNITS/DAY	

17.11.F(6) Drug to Drug Interactions

Purpose: Provides a warning when the potential for a severe interaction is identified between the current prescription and an active prescription in the participant's prescription history file. Individual ingredients of combination products are utilized in the screening process. Multiple interactions are possible.

DD—Drug-Drug Interactions

The "Drug-Drug Interactions" warning message is issued when a severe interaction is found between the current prescription and an active prescription in the participant's history profile.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	DD	(Drug-Drug Interactions)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	06/22/99	
Quantity of Previous Fill	00030	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	1	(Same Prescriber)
Free Text	ALLOPURINOL/THIOPURINES	

17.11.F(7) Drug Disease Contraindications

Purpose: Provides a warning message when a contraindication is found between a current prescription and a specific condition indicated on the participant's medical or prescription history profile.

MC—Drug (Actual) Disease Precaution

The "Drug (Actual) Disease Precaution" warning message is issued when a contraindication is identified between the current prescription and a specific diagnosis found on a medical claim in the participant's medical history profile.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	MC	(Drug-(Actual) Disease Precaution)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	0	(No Value)
Previous Date of Fill	00000000	
Quantity of Previous Fill	00000	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	0	(No Value)
Free Text	SALICYLATES/BLEEDING ULCER	

DC—Inferred Drug Disease Precaution

The "Inferred Drug Disease Precaution" warning message is issued when a contraindication is identified between the current prescription and a condition indicated by another active prescription found in the participant's prescription history profile. For example, and active prescription for Phenytoin in the participant's prescription history profile would indicate a condition of seizure disorder.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	DC	(Inferred Drug Disease Precaution)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	07/01/99	
Quantity of Previous Fill	00001	
DataBase Indicator	1	(First DataBank)

Other Prescriber Indicator	1	(Same Prescriber)
Free Text	ANOREXIANTS/HYPERTENSION	

17.11.F(8) Duplicate Therapy

Purpose: Provides a check for duplication between the current prescription and an active prescription in the participant's prescription history profile. Duplication within certain classes (*not* the identical drug) as well as identical drug or ingredient duplication is identified by this screening module.

TD—Therapeutic Duplication

The "Therapeutic Duplication" warning message is issued when a current prescription has the same route of administration and contains an ingredient from the same therapeutic class as an active prescription in the participant's prescription history profile.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	TD	(Therapeutic Duplication)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	07/01/99	
Quantity of Previous Fill	00030	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	1	(Same Prescriber)
Free Text	ANALGESICS,NARCOTICS	

ID—Ingredient Duplication

The "Ingredient Duplication" warning message is issued when a current prescription contains an ingredient also found in an active prescription in the participant's prescription history profile. Ingredients of combination products are screened individually.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	ID	(Ingredient Duplication)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	3	(Other Pharmacy)
Previous Date of Fill	07/08/99	
Quantity of Previous Fill	00010	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	1	(Same Prescriber)
Free Text	PROPOXYPHENE HYDROCHLORIDE	

17.11.F(9) Side Effects

Purpose: Provides a screening of the current prescription against the participant's prescription and medical history profiles to identify the following potential drug therapy problems:

* Significant additive side effects - A side effect of the current prescription is identical to a side effect of an active prescription on the participant's prescription history profile.
* Significant medical condition/additive side effect - A side effect of the current prescription is identical to a diagnosis found in the participant's medical history profile or to a condition inferred by an active prescription on the participant's prescription history profile.
* Significant side effect - A serious potential side effect of the current prescription is identified.
* Drug indicated for side effect of previously prescribed drug - The current prescription is used to treat a side effect of a previous dispensed prescription found in the participant's prescription history profile.

AT—Additive Toxicity

The "Additive Toxicity" warning message is issued when the side effect of a current prescription matches the side effect of an active prescription in the participant's prescription history profile.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	AT	(Additive Toxicity)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	07/01/99	
Quantity of Previous Fill	00090	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	1	(Same Prescriber)
Free Text	THROMBOCYTOPENIA	

MC—Drug (Actual) Disease Precaution

The "Drug (Actual) Disease Precaution" warning message is issued when a side effect identified for the current prescription is identical to a diagnosis found on the participant's medical history profile or identical to a condition inferred by an active prescription found on the participant's prescription history profile.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)
(when found using participant's medical profile)

Drug Conflict Code	MC	(Drug (Actual) Disease Precaution)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	0	(No Value)
Previous Date of Fill	00000000	
Quantity of Previous Fill	00000	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	0	(No Value)
Free Text	GLAUCOMA, NARROW ANGLE	

NCPDP Version 3.2/3.C Response (NCPDP Field #525)
(when found using participant's prescription profile)

Drug Conflict Code	DC	(Inferred Drug Disease Precaution)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	07/01/99	
Quantity of Previous Fill	00090	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	1	(Same Prescriber)
Free Text	GLAUCOMA, NARROW ANGLE	

SE—Side Effect

The "Side Effect" warning message is issued when a significant side effect is identified for the current prescription.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	SE	(Side Effect)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	0	(No Value)
Previous Date of Fill	00000000	
Quantity of Previous Fill	00000	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	0	(No Value)
Free Text	DIZZINESS	

PR—Prior Adverse Drug Reaction

The "Prior Adverse Drug Reaction" warning message is issued when the current prescription is indicated for the side effect of a previously prescribed drug.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	PR	(Prior Adverse Drug Reaction)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	07/01/99	
Quantity of Previous Fill	00090	
DataBase Indicator	1	(First DataBank)
Other Prescriber Indicator	1	(Same Prescriber)
Free Text	QUINIDINE GLUCONATE/SYSTEMIC R	

17.11.F(10) Duration of Therapy (H2 Antagonist)

Purpose: This module was developed by the MO HealthNet Division with the approval of the DUR Board to screen for possible inappropriate long term use of this therapeutic class. It has been determined, for the purposes of this module, that a course of therapy of this therapeutic class at therapeutic dose should *not* exceed 90 days in any 120 day period. A calculation is made with the submission of each prescription within this class to determine whether the quantity dispensed represents a therapeutic or maintenance dose. Various messages are issued to alert providers to the status of a participant in terms of the 90 day course of therapy.

MX—Excessive Duration Alert

The "Excessive Duration Alert" warning message is issued when a participant exceeds 90 days of H2 Therapy within the last 120 days.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	MX	(Excessive Duration Alert)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	00000000	
Quantity of Previous Fill	00000	
DataBase Indicator	5	(Other)
Other Prescriber Indicator	1	(Same Prescriber)

Free Text	RX EXCDS 90DAY THER BY 053DAYS

MX—Excessive Duration Alert

The "Excessive Duration Alert" warning message is issued when the current prescription causes the previous prescription to be recalculated as a therapeutic dose. This recalculation causes the participant to exceed 90 days of H2 Therapy within the last 120 days.

NCPDP Version 3.2/3.C Response (NCPDP Field #525)

Drug Conflict Code	MX	(Excessive Duration Alert)
Severity Index Code	1	(Major)
Other Pharmacy Indicator	1	(Your Pharmacy)
Previous Date of Fill	00000000	
Quantity of Previous Fill	00000	
DataBase Indicator	5	(Other)
Other Prescriber Indicator	1	(Same Prescriber)
Free Text	PREV RX EXCDS 90DAY BY 0005DAYS	

Duration of Therapy Status Messages

Duration of Therapy Status Messages appears in the message area of a paid prescription (NCPDP Field #504) in NCPDP Versions 1.0, 3.2, and 3.C. Duration of Therapy Information messages are issued for the following reasons:

* Current prescription is at a therapeutic level and initiates the beginning of 90 days of H2 therapy.

RX INITIATED 90 DAY H2 THERAPY
|_____Message Text

* Previous prescription was recalculated to a therapeutic level and initiated the beginning of 90 days of H2 therapy.

PREV RX INITIATED 90 DAY THER
|_____Message Text

* Previous prescription was recalculated to a therapeutic level and was applied to 90 days of H2 therapy.

PREV RX APPLIED TO 90 DAY THER
Message Text

* Current prescription is at a therapeutic level and was applied to 90 days of H2 therapy.

012 DAYS OF 90 DAY H2 THER USED
Message Text

* Current prescription is an H2 drug at a maintenance dose.

H2 MAINTENANCE DOSE
Message Text

* Current prescription is an H2 drug billed out of sequence.

H2 OUT OF SEQUENCE
Message Text

17.11.F(11) DUR Overflow Indicator

The DUR Overflow Indicator identifies when a prescriptions contains more DUR messages than can be displayed. NCPDP Version 3.2/3.C displays three DUR messages.

17.12 TRANSPLANT PAYOUTS

Refer to Section 17 of the Transplant Addendum.

END OF SECTION

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